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A study of the effectiveness of Rational Emotive Therapy with a Clinical Population

by

Bruce Monkhouse

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A THESIS

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Abstract

The efficacy of Rational Emotive Therapy (RET), was compared with an unstructured therapeutic approach in a population of thirty-one women and men at the Edmonton General Hospital. Twenty-one of the subjects were psychiatric outpatients referred to the psychiatric day therapy program. The remaining ten, comprising a group who underwent no therapy, were employees of the hospital. The group was set up to control for time and testing.

The treatments were conducted over a total of twelve therapy sessions in a four-week period. The degree of psychological adjustment to anxiety, assertiveness and irrational beliefs were measured using the IPAT (overt, covert and total anxiety scale), the Gambrill-Richey Assertiveness Inventory and the Irrational Beliefs Inventory. The effect of time was examined by administering pre- and post-test measures for each of the scales. The data were analyzed using a two-way analysis of variance with repeated measures on one factor. Differences between the groups were tested for significance using the Scheffe post hoc multiple comparisons test. The results indicated that RET was as effective as unstructured therapy in reducing anxiety and irrational thinking but was superior to the latter in improving the likelihood of making an assertive response.

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CHAPTER 1

Introduction

One of the central areas of contemporary research in the field of psychology that is of direct relevance to this study, is the trend to theorize and analyze the various cognitive factors involved in human action and emotion.

Just as traditional behaviorism laid the groundwork for the development of various behavior therapies, so too has the cognitive behavioral school facilitated the growth of what is now called cognitive-behavioral approaches to psychotherapy. The therapies included under this title are based, by and large, on the premise that altering existing cognitive patterns is essential for psychotherapy to be successful. The fundamental assumption is that psychopathology is the result of distorted, maladaptive and irrational thoughts, beliefs and attitudes. The therapeutic techniques that have been developed to ameliorate these faulty patterns of thinking are therefore primarily involved in cognitive restructuring. The most prominent of the cognitive behavioral approaches to emotional disturbance include: Ellis's Rational Emotive Therapy (RET) (1962, 1973), Beck's Cognitive Therapy (1976) and Meichenbaum's Cognitive Behavior Modification (1977). Albert Ellis's Rational Emotive Therapy has been chosen for study in this

work.

Historical Development

A number of cognitive therapists, including Ellis (1962), Beck (1976) and Meichenbaum (1977), have traced the roots of the approach to the Greeks, who suggested that the alteration of thinking patterns results in changes in behavior. Meichenbaum (1977) cites a number of psychotherapists including Dubois (1905), and Beck (1976) who "have emphasized the role of cognitive factors in contributing to mental illness and have focused on altering the client's maladaptive self-verbalizations" (1977, p. 184). As well, psychologists such as Rotter (1954) and Kelly (1955) both stressed the importance of conscious thought in mediating human behavior.

The notion that the person, particularly one's internal processes and perceptions, at least in part determines behavior is hardly an original idea to anyone aware of the analytic and humanistic schools of psychotherapy. It does however, represent a dramatic departure from traditional behavior therapy (cf. Skinner, 1953; Wolpe, 1973). Researchers focusing on externally observable events, contingencies of reinforcement, and the association between stimulus and response, have previously insisted that internal behaviors were not readily amenable to controlled measurement. The recent shift in emphasis to include cognitive factors in behavior therapy has not been

universally accepted. A number of behaviorists see this new approach as moving in a counter-productive direction. Labels such as "cognitive exclusivism" and the concern that the recent emphasis on the study and measurement of mediational variables represents a "resurgence of mentalism" is understandable if one considers the fact that the behavioral learning orientation arose largely as a reaction to the insight-oriented psychotherapies (Wolpe, 1973). However, Meichenbaum (1977) argues that the cognitive approach does not abandon respondent and operant conditioning principles. On the contrary, much of the theoretical basis of the cognitive behavior approach arises from reinforcement theory. The therapies of Beck and Ellis represent the rather extreme position in the cognitive-behavioral school (ie. the suggestion that thought produces maladaptive behavior). However, they do maintain a commitment to operationalize hypothetical constructs in such a way that they are amenable to empirical investigation and replication.

Cognitive Behavior Therapy

The most recent discernable development within behavior therapy is the emergence of what can be loosely described as the "cognitive connection". Rational Emotive Therapy is subsumed under the general heading of cognitive behavior therapy (Ellis, 1973). Cognitive Behavior Therapy is in turn encompassed by the larger category of behavior therapy.

Behavior therapy has historically been viewed in terms of respondent, operant and social learning models for producing therapeutic change.

During the last two decades another approach emphasizing the role of cognitive mediational variables as critical determinants in the production, maintenance and modification of dysfunctional behavior has attracted an increasing number of proponents. The cognitive learning approaches reflect an integration of two important perspectives in clinical psychology, internalism and behaviorism (Mahoney, 1974). Internalism assumes that the major determinants of human behavior reside within the individual. The referents include Ellis's RET, Meichenbaum's Cognitive Behavior Modification and Beck's Cognitive Therapy. These individuals stress the importance of examining and utilizing variables such as belief systems, attitudes and patterns and content of thought for the modification of emotional and instrumental behavior.

It is somewhat difficult to categorize the admixture of diverse principles and procedures encompassed by the term cognitive behavior therapy. Mahoney (1980) has set out the following commonalities:

1. that humans develop adaptive and maladaptive behavior and affective patterns via cognitive processes (selective attention, symbolic coding etc);
2. the role of the therapist is that of a diagnostician-educator whose task it is to assess

maladaptive cognitive processes and subsequently rearrange learning experiences to change cognition and in turn, the behavior-affect pattern.

Cognitions are viewed as obeying the same psychological laws as overt behaviors and are therefore susceptible to similar manipulations (Bandura, 1969). Meichenbaum and Cameron (1973) stated in their research on cognitive factors in behavior therapy that:

> Our research in cognitive factors in behavior modification has high-lighted the fact that it is not the environmental consequences per se which are of primary importance , but what the subject says to himself about the consequences. However, what S says to himself, that is, how he evaluates and interprets these events, is explicitly modifiable by many of of the behavior therapy techniques. (p.169)

The central theme of cognitive behavior therapy is that an individual's emotional responses are determined by one's perceptions and interpretations of events. Beck observed several parallels between behavior therapy and cognitive behavior therapy. Therapists in both systems are active and structure the sessions overtly. They employ detailed instructions and procedures aimed at shifting symptom frequency, intensity or magnitude. Both cognitive and behavior therapists adhere to the basic tenet that maladaptive behavior is acquired and can be unlearned. The cognitive behavior therapists assist their clients to recognize and challenge their disturbed beliefs and distinguish between rational and irrational ideas.

Cognitive Behavior Research

Cognitive Behavior Therapies (Beck, 1976, Ellis, 1962) are based on the same basic assumption that emotional disturbances are caused by cognitive distortion. The research using CBT has been conducted largely with depressed and anxious individuals. Rimm & Litvak (1969) demonstrated that self-verbalizations elicit emotional responses. Their subjects were found to display greater emotional arousal to those sentences of an affective nature than to neutral sentences. Rush, Khatomi and Beck (1975) examined the case histories of patients suffering from chronic depression and who were treated with a combination of cognitive and behavioral techniques. The results as measured by the Beck Depression Inventory and the Hamilton Rating Scale indicated that these techniques were successful. Shaw (1977) compared the efficacy of the cognitive approach put forward by Beck and Lewinsohn's behavioral approach in the treatment of depression. The results indicated that the cognitive treatment was significantly more effective than all other intervention strategies in reducing depressive symptomatology.

Taylor and Marshall (1977) compared cognitive therapy based on Beck's model with a behavioral approach, a combined treatment strategy and a no-treatment control group. The subjects were 28 moderately depressed college volunteers, ranging from 18 to 26 years of age. None of the subjects was currently involved in any form of treatment for

depression. The results suggested that all therapy groups did significantly better than the control group. The combined treatment did better than either treatment alone.

The research reviewed in this section is representative rather than exhaustive. Many other theoretical applications and studies (eg. self-control, coping skills, problem solving) have now been subsumed under the term cognitive therapy and are beginning to attract considerable clinical interest and cautious support.

Purpose of the Present Study

Mental health surveys indicate that up to 85% of the total North American population is in some way affected by psychological problems, and the annual prevalance of all emotional disorders affects approximately 15% of the population per year (Reiger, Goldberg & Taube, 1978). It is clearly evident to those professionals working in the field of mental health that the current facilities and labour are insufficient to meet the demands of all those requiring treatment. It is therefore essential to investigate the effectiveness of treatment strategies and the methods used to implement them.

Rational Emotive Therapy is one of the few psychotherapies whose efficacy has been demonstrated in analog research. However, the vast majority of these studies have utilized college volunteers as subjects. Despite the overall favourable outcome of these studies

there is a definite need for further research using Ellis's theoretical orientation in a clinical setting. Mahoney (1974) in his work on cognitive behavior therapies explicitly stated that the "clinical efficacy of RET has yet to be adequately demonstrated" (p.182). The possibility that effective behavioral procedures in concert with recognized cognitive variables can be be utilized to treat individuals in distress represents a new and promising direction in psychotherapy.

The purpose of this study was to investigate the effectiveness of RET in dealing with assertiveness, anxiety and irrational beliefs amongst a psychiatric outpatient population in a group day therapy setting at the Edmonton General Hospital. A cognitive therapy group based on RET principles was compared with a group of patients involved in the day therapy program who were not receiving RET and a group of individuals randomly selected from personnel who were not receiving psychiatric treatment of any kind. In addition, the ramifications of Ellis' argument that "all rational persons are mentally healthy, and all mentally persons are assertive, therefore all rational persons are assertive" will be explored (Vargo, 1972, p.38).

Delimitations and Limitations of Present Study

This study was delimited in that the experimental sample was comprised of psychiatric outpatients attending

the day therapy program at the Edmonton General Hospital. The no-treatment group was made up of personnel from the departments of social work, psychology, support services and nursing.

The study was methodologically and theoretically limited in a number of ways. The treatment groups represented only a limited section of the psychiatric outpatient population in Edmonton. The no-treatment group was not chosen from a psychiatric population but was chosen from hospital personnel not receiving treatment. The study was conducted over a four week period, and the effects of medication and visits to attending physicians were not controlled. With respect to limitations of the theoretical model, the underlying premises of RET have as yet only been studied in North America. No cross-cultural empirical studies of Ellis's approach have been attempted. As well, the wide range of techniques utilized by RET practitioners and the lack of specificity with respect to precisely what procedures to follow, detracts from drawing firm conclusions when comparing RET outcome studies.

CHAPTER 2

Theory and Related Literature

Genesis of Rational Emotive Therapy

According to Albert Ellis (1962,1979), the originator of RET, human emotions directly stem from the ideas, thoughts, attitudes and beliefs that people have developed about other people, situations and events with which they have interacted. He accepts the proposition that people can learn to control their cognitive processes, thereby affecting their emotional reaction to events.

Proponents of Alfred Adler's view of psychopathology are quick to point out that the importance of cognitions in understanding human behavior is hardly a new development. Adler's (1927) individal psychology theorized that a person's emotional responses are cognitively created and the basic beliefs and ideas which a person hold are related to the individual's psychological health. However, the philosophical origins of RET go back much farther than to Adler. Epictetus , a stoic philosopher, wrote in 60 A.D. that: "Men are disturbed not by things but by the view which they take of them" (cited in Ellis, 1962).

One of the focal points of Rational Emotive Psychotherapy is Ellis's argument that humanity is both

rational and irrational and that most psychological disturbances are a product of irrational or illogical thinking. To rid oneself of these emotional problems one must learn to maximize rational thinking and minimize irrational thinking. Consequently, the therapist's basic task is to assist the client in coming to understand that psychological problems are a result of inaccurate perceptions and illogical thoughts and that the cause of emotional problems can be eliminated by learning to perceive more accurately and think more rationally (Vargo, 1972).

RET makes certain assumptions about the nature of human beings. These include the notion that:

1. Human beings are born with a potential to be uniquely rational and straight thinking, as well as a tendency to be uniquely irrational. When they are thinking and behaving rationally, they are effective and competent.
2. Human beings have a tendency to think irrationally, engage in self-damaging habits and behave intolerantly. These actions are frequently exacerbated by one's culture in general and one's family group in particular. This is especially evident when one is a child and most vulnerable to outside influences.
3. Human beings tend to perceive, think, emote and behave simultaneously and interactionally. Therefore a person is at one and the same time, cognitive, conative and motoric.
4. Human beings are verbal animals, and thinking usually

occurs through the use of symbols or language. Since thinking accompanies emotion and emotional disturbances, irrational thinking necessarily persists if the emotional disturbance continues. According to Albert Ellis, this is what characterizes psychologically disturbed individuals. People maintain their problems and illogical behavior by internal verbalization of their irrational ideas and thoughts. This perpetual self-stimulation is the reason that disordered behavior and emotions are not extinguished.

5. Continuing states of emotional disturbance which are a result of self-verbalizations are thus determined, not by external circumstances or events, but by the perceptions and attitudes toward these situations.
6. Virtually all serious emotional problems with which humans are beset originate directly from their superstitions, and empirically invalid thinking. If these ideas are vigorously and persistently disputed by the application of the principles of logico-empirical thinking, faulty cognitive paterns can be altered.

The basic view of RET then, is that sustained negative emotions are by and large, either a form of illogical thinking or the result illogical thinking. The emotionally disturbed person accepts self-defeating ideas, ingrained by parents, society, culture, and symbols of authority (Vargo, 1972). Ellis (1962) has proposed eleven such irrational ideas which pervade our culture, and when perpetuated these

lead to neurotic self-defeating behavior. These irrational notions are as follows:

1. It is an absolute necessity for adults to be loved or approved by everyone for everything they do - instead of concentrating on their own self-respect, and on winning approval for necessary purposes.
2. Adults should be thoroughly competent, adequate, intelligent and achieving in all possible respects if they are to be considered worthwhile - instead of the idea that they should always try to do their best, that they should accept themselves as imperfect and that everyone has fallibilities.
3. Certain people are bad or wicked and should be punished for their villainy instead of the idea that certain acts are inappropriate or antisocial and that people who perform such acts need help.
4. It is awful and catastrophic when things are not the way one would like them to be - instead of the idea that it is too bad when things are not the way one would like them to be and one should certainly try to change or control conditions, but if this is not possible, one had better become resigned to their existence and stop telling oneself how awful they are.
5. Unhappiness is externally caused and people have little ability to control their disturbances - instead of the idea that almost all unhappiness is sustained by the view one takes of things rather than the things

themselves.

6. If something may be fearsome one should be terribly concerned about it and keep dwelling on it - instead of taking some action to alleviate the danger.
7. It is easier to avoid than to face certain life problems and personal responsibilities.
8. One should be dependent on others and always need someone stronger than oneself on whom to rely - instead of the idea that it is far better to stand on one's own two feet.
9. One's past history is the all-important determiner of one's present behavior - instead of the idea that one should learn from one's past experiences.
10. One should become quite upset over other people's problems - instead of the idea that other people's deficiencies are largely their problem.
11. There is invariably a right, precise and perfect solution to human problems and it is catastrophic if this perfect solution is not found - instead of the idea that one should be able to choose from amongst the best available alternatives.

(Ellis, 1958, p.40-41, Ellis, 1962, p. 60-68, Zingle, 1965, p.13-16).

Ellis states that the repetition of these early-acquired irrational beliefs to oneself is a major contributing factor in creating emotional disturbance.

Personality Change and RET

Physiological Basis of Personality

Unlike most of the other systems of psychotherapy, RET strongly emphasizes the biological aspects of human personality. Rational emotive psychology acknowledges that man is often "naturally" inclined to do X rather than Y; the family and culture in which one is reared, wittingly or unwittingly, reinforces this choice that only with concentrated and determined effort will the individual change. Simply stated, this is largely an environmentalist position, which is physiologically and genetically based since only an innately predisposed individual would be prone to environmental factors (Corsini, 1976, p. 175).

Although Ellis holds that humans have a vast potential for growth and, in many ways, are able to change their social and personal destiny, he does admit that people have exceptionally powerful innate tendencies to think irrationally, and to harm themselves. Certain patterns of self-defeating and socially uncooperative behavior are accompanied by the following tendencies:

1. to be overwhelmed frequently by inertia, or by great difficulty experienced in changing thought and action;
2. to greatly desire many patently harmful goals and things and to convince oneself that one needs, or must have, what one merely wants or prefers; that is, to relegate

any wish or passing fancy to the level of need;

3. to find it most difficult to unlearn even the most inefficient habits once one has fully learned them;
4. to remain attached to many familial, cultural, religious prejudices and myths which he learned during childhood;
5. to be overvigilant and overcautious on innumerable occasions;
6. to be sorely bothered all his life with the "need" to prove to himself and to others that he is infinitely superior to his fellowmen;
7. to easily jump, when one of his views proves to be ill-founded;
8. to frequently resort to unthinkingness, when his better interests would be served by conscious thinking or rethinking;
9. to keep forgetting that something is noxious, even when the evidence is readily apparent;
10. to engage in enormous amounts of wishful thinking;
11. to find it "too hard" to sustain valuable efforts and self-discipline;
12. to demand rather than to want people to treat him justly;
13. to condemn himself totally, instead of assessing poor behavior;
14. to overgeneralize mightily about events that have occurred in the past or may occur in the future;
15. to easily become physically or psychosomatically

affected when he makes himself emotionally upset (Corsini, 1976, P. 175-176).

According to Ellis, human beings are born with a strong tendency to want and to insist that everything happens for the best in life and to condemn themselves and, others when their wishes are not immediately fulfilled. This is not to deny, as Rogers (1971) and many other Third Force psychologists argue that the individual has an impressive self-actualizing capacity and a need to be rationally self-critical. Unfortunately the capacity to self-actualize is all too frequently sabotaged by inborn and self-acquired beliefs and attitudes.

Social Aspects of Personality Change

Human beings are reared in social groups and spend a significant proportion of time attempting to live up to the expectations of others. This becomes problematic when people believe that they can only be self-accepting if others think well of them. On the other hand, if a person comes to believe that acceptancee is not necessary from anybody, emotional disturbance will also occur. Emotional maturity then, would be achieved when there is a balance between the individual's caring, and over-involvement with respect to interpersonal relations .

Psychological Aspects of Personality

According to RET, an individual has few if any "instincts" in the classical sense of the term but has a number of "instinctual" tendencies as Maslow (1970) indicates. That is, a person easily wants to be loved and cared for rather than disliked, and to have one's needs fulfilled rather than frustrated.

The basic tenet of RET is that emotional disturbance, as distinguished from occasional and situational feelings of sorrow and annoyance, are created by the person's irrational beliefs. These beliefs are irrational because they result in the person insisting that something in one's environment should, ought or must be different than it currently is, when in fact, change is not imminently possible. For example, Ellis cites Cobb's definition of emotion as: "(1) an introspectively given affect state, usually mediated by acts of interpretation; (2) the whole set of internal philosophical changes, which help the return to normal equilibrium between the organism and its environment and (3) the various patterns of overt behavior, stimulated by the environment and implying constant intervention with it, which are expressive of the stirred-up physiological state" (Ellis, 1962, p. 39). This means that whenever individuals are faced with a disturbing event at point A (the Activating Event) and feel emotionally upset at point C (the Consequences that follow the Activating Event) they must invariably convince themselves of two radically different

things in their belief system (Point B). The first is a reaction that is quite appropriate and rational - "I wish that event had not happened; it is undesirable that it has taken place." If the person would stay with this rational belief, the likelihood of becoming upset, discouraged, or depressed is lessened. However, when the person feels upset at point C and convinces himself of a highly inappropriate belief, such as "I am a worthless stupid person for not being able to accomplish this task." This irrational belief is inappropriate because (1) it can not be empirically validated or disproved and (2) rather than assisting the person to go back to the activating event and change or resolve it, the irrational belief system almost invariably interferes with one's ability to perceive/interpret the events rationally at point A and (3) it leads to unpleasant consequences such as increased levels of anxiety. Ellis argues that this type of irrational belief is not empirically valid because one can stand the noxious activating event even though one may never like it. By holding that negative events in life should not exist, an individual is in effect attempting to exert complete control over one's entire existence which is clearly impossible.

In summary, the basic personality theory of RET argues that human beings are largely responsible for the creation of their own emotional consequences, that they have an innate propensity to irrational cognitions and learn through social conditioning to maximize rather than minimize the

likelihood of their occurrence. However, human beings also have a unique ability to clearly understand how their belief systems can create emotional disturbances and how to change or eliminate these self-defeating beliefs. These changes take place through a highly directive, didactic approach which focuses on the content of a person's beliefs and means of altering them, thereby helping the person become more rational and mentally healthy.

RET Theory and Practice

According to Rational Emotive Therapy, emotional disturbances occur when one person insists that one's wishes be satisfied all the time in every circumstance. When the emotionally disturbed individual behaves in this way, then the relevant quetions which can be raised irrespective of the particular therapy being used are:

1. How do people get to the position of thinking and behaving irrationally?
2. How have they been maintaining such behavior?
3. How can they be helped?

Many of the more traditional therapeutic techniques advocated by the humanistic and existential schools, show the clients that their thinking and behaving is illogical and provide insight into the origins of such behavior. However these approaches usually stop short of directly showing the clients how they are presently maintaining their illogical thinking and precisely what they must do to change

it.

From Ellis's perspective, an effective therapist should continually unmask the client's past and at the same time focus on current illogical thinking and self-defeating verbalizations. The rational therapist does this by:

(a) bringing the irrational philosophies to the client's conscious awareness;

(b) showing him how they are maintaining the present disturbances;

(c) demonstrating precisely what the illogical links in his internalized sentences are; and

(d) teaching him to rethink these and other similar sentences.

When utilizing RET, the role of the therapist is to "serve as a frank counter-propogandist who directly contradicts and denies the self-defeating propoganda and superstitions which the client has originally learned and which he is now self-propogandistically perpetuating. As well, the therapist encourages, persuades, cajoles, and at times commands the client to partake in some kind of activity which itself will act as a forceful counter-propogandist agency against the nonsense he believes" (Ellis, 1958, p.45).

The attempt to help individuals minimize their absolutist and dogmatic philosophy is carried out by utilizing three major approaches within an RET framework. These approaches are cognitive, emotive-evocative, and

behavioristic in their orientation. The cognitive approach attempts to convince individuals of the necessity of altering some of their perfectionistic attitudes and beliefs in order to lead a happier and more relaxed existence. It teaches them how to find their should, ought and must statements, and then how to differentiate their rational from their irrational beliefs. RET works on the premise that clients can think, and can think about their thinking, and thereby become more aware of their own cognitive processes. It employs a one-to-one Socratic form of dialogue between the client and the therapist in individual interaction and in group therapy situations. It encourages other members of the group to discuss, explain and reason with other group members who are functioning irrationally.

The emotive-evocative approach is used to help clients look at their basic values. The therapist may use role-playing to demonstrate clearly to clients their ideas; modeling to show how to adopt more effective and functional values; humor to reduce some of the client's disturbance-creating ideas; and unconditional acceptance of the client to demonstrate to them that they are acceptable, even with their failings (Corsini, 1976).

The behaviorist approach is utilized not only to help clients alter their dysfunctional symptoms and to become habituated to more effective ways of acting but also to help them change their cognitions about themselves and others. The therapist may do this by giving the client assignments

either in the therapy sessions themselves, or as homework, to gradually take risks by changing current patterns of behavior. RET often emphasizes operant conditioning to reinforce the individual's change in behavior.

Ellis sees Rational Emotive theory of psychotherapy as the most effective and efficient because it requires less time spent in therapy sessions, works with a diverse clientele, and provides long term relief of symptomatic behaviour for the client. Additionally, supporters of RET argue that it works substantially better than other therapies because it is based on philosophical principles that combat the unrealistic demands that characterize many emotional disturbances.

Rational Emotive Therapy in a Group Setting

According to Albert Ellis (1973a), Rational Emotive Psychotherapy lends itself to a group setting. The basic goals of group psychotherapy utilizing RET principles are twofold. The first is to provide an atmosphere in which the participants can feel psychologically comfortable and can therefore open up to each other about their thoughts, beliefs and feelings. The second goal is to assist the group members to understand why they behave in certain important ways and to understand further the philosphical underpinnings of one's inappropriate emotions and behaviors (Sharma, 1970).

Some of the major advantages of rational group therapy over individual therapy include:

1. The setting provides a therapeutic climate where members feel free to share experiences with each other.
2. Members act as auxiliary therapists. The combined influence of the group members when brought to bear on an individual member's irrational beliefs is generally more effective in changing his self-indoctrination than if the therapist is alone.
3. Homework assignments, given during group therapy, are more often carried out to completion than when given on an individual basis.
4. The discrepancy between what the individual says and does is often more explicit in a group setting, where more people are aware of actual conduct. The reduction of these discrepancies is therefore more likely to occur.
5. Finally, it is logical to assume that a group of people are capable of generating a greater number and variety of hypotheses about problems and solutions than an individual.

In many respects, therefore, rational emotive group therapy has concrete advantages over individual psychotherapy (Ellis, 1973a, P.174).

Selected Research Findings

The relationship between the endorsement of RET's irrational ideas and emotional disturbance has been investigated in a number of studies. Empirical investigations exploring the fundamental tenets of Rational Emotive psychotherapy have been essentially of four kinds:

1. reports and case histories regarding RET effectivenss
2. development and application of inventories designed to measure irrational beliefs and
3. Non-Comparative outcome studies
4. Comparative outcome studies

Reports and Case histories

The first documented attempt to compare the efficacy of RET with other psychotherapeutic approaches was conducted by Ellis (1957). For his study, Ellis withdrew from his files 78 closed cases of persons treated with RET and then compared them on the basis of age, sex, education and diagnosis with 78 cases of individuals who had been treated using psychoanalytically-oriented psychotherapy. Each group contained 61 neurotics, and 17 borderline psychotics all of whom had been seen for at least 10 sessions. Each person's degree of improvement was rated on a three-point scale (little or no improvement, some distinct improvement, and considerable improvement) and were reported in terms of their percentage of success. For orthodox psychoanalysis:

little or no improvement, 50%; distinct improvement, 37%; considerable improvement, 13%. Psychoanalytically-oriented psychotherapy: little or no improvement, 27%; distinct improvement, 45%; considerable improvement, 18%. Rational-emotive therapy: little or no improvement, 10%; distinct improvement, 46%; considerable improvement, 44% (cited in Vargo, 1972).

Zingle (1965) was amongst the first to employ no-treatment control group procedures in testing the success of RET. Sixty high school underachievers were assigned to one of four groups, each group matched for degree of underachievement, scholastic aptitude, grades, sex, and socio-economic status. Each student in Group A received approximately eight individual sessions of RET counseling, each session lasting 25-35 minutes; students in Group B saw a school counselor for the same amount of time as students in Group A, however, they underwent regular school counseling with emphasis being placed on study schedules; Group C received "laggard student" letters which threatened to expel them if grades were not improved ; Group D underwent no treatment. In terms of pre-post measures of marks and irrational ideas, there was a statistically significant difference between Group A and Group D, indicating that RET is more effective than no treatment.

Correlational Studies of Irrational Ideas

Jones (1969) developed an instrument designed to measure endorsement of irrational beliefs. Item selection

was based on factor analysis, and the test consisted of 100 items measuring 10 irrational beliefs on separate scales. The Irrational Beliefs Test (IBT) was given to a population of 427 subjects. All subjects were also given two paper and pencil measures of common psychiatric symtpoms. The results indicated that 8 of the 10 Irrational Belief Scales correlated highly with admitted symptomatology and self-reports of anxiety. The author concluded that high endorsement of irrational ideation is a valid indication of psychopathology, although no causal relationship was implied.

Trexler and Karst (1973) provided support for the validity of the IBT. Predicted changes in IBT total scores as compared to placebo and no treatment groups were demonstrated.

MacDonald and Games (1972) conducted three studies to determine the internal consistency of Ellis's eleven irrational ideas and to cross-validate them with other psychological inventories. In the first study, 61 undergraduate students were asked to rate from 1 (completely disagree) to 9 (completely agree) their opinions of each of the 11 Irrational Beliefs set out by Ellis. The results indicated that 9 out of the 11 ideas were significantly related to the total scores. The second study cross-validated the irrational ideas with the California Personality Inventory (CPI) using 37 graduate students. The endorsement of Irrational Beliefs was significantly

correlated with 13 out of 18 subscales of the CPI. A third study, using 84 undergraduate students, studied the relationship between irrational ideation, the Eysenck Personality Inventory and the Taylor Manifest Anxiety Scale. The results demonstrated that adherence to irrational ideation was positively associated with neuroticism , manifest anxiety and external locus of control.

Newmark (1972) investigated the opinion of mental health professionals concerning Ellis's 11 major irrational beliefs, by sending 900 questionnaires to clinical psychologists, social workers and psychiatrists. The return rate was 54 percent. The results of the survey indicated that clinical psychologists and social workers concurred in their endorsement of irrational beliefs one, two, four, six, ten and eleven as probable precipitants of emotional difficulties , while psychiatrists endorsed ideas one, two and eleven. Clinical psychologists and social workers also demonstrated significantly higher percentages for several irrational beliefs when compared with psychiatrists. Newmark attributed the psychiatrists' relatively low endorsement rates of irrational ideas to their strict adherence to Freudian prinicples as primary causes of emotional disturbance.

Kassinove, Crisci, and Tiegerman (1977) investigated developmental trends in rational thinking, measured by the extent of endorsement of Ellis's 11 irrational ideas. The first two authors, in formulating the Idea Inventory,

constructed a pool of 55 statements and then independently selected 33 items for the final version. Each of the 11 irrational ideas was represented by 3 items, including the original statement of the idea. The scale was adminstered to 36 college students asked to respond to each item on a 3-point scale from 1 (agree) to 3 (disagree). To assess the reliability of the scale, the 33 items were divided into thirds. Correlations of each third with the residual two thirds were .84, .90 and .91. To assess validity, total scores on the idea inventory were correlated with neuroticism scale scores on the Eysenck Personality Inventory and with the Bell Adjustment Inventory. Significant correlations were obtained between total Idea Inventory scores and neuroticism scores. There was also a significant correlation between the total Idea Inventory score and the five adjustment area scores of the Bell Inventory.

Gormon and Simon (1978) assessed the relationship of irrational thinking and various personality types. Their subjects were 100 undergraduate students who were administered the Idea Inventory and the Sixteen Personality Inventory (16PF). The results showed a significant correlation between endorsement of the irrational ideas and seven of the 16 scales. The seven scales were: "easily upset", "tenderminded, dependent", "suspicious, self-opionated", "apprehensive, worried, depressive", "careless, follows own urges", and "tense, driven,

overwrought". The results did not indicate that rationality/irrationality was associated with the introversion/extroversion factor. The authors concluded that high endorsement of irrational ideas is higly correlated with maladaptive behavior and emotional disturbance.

Godfried and Sabocinski (1975) investigated the relationship between irrational ideation and emotional arousal. Their study used 77 undergraduate females who completed a questionaire battery including Jones Irrational Beliefs Test, Social Avoidance and Distress Scale, the Fear of Negative Evaluation Scale, the Achievement Anxiety Test, and the Personal Report of Confidence as a Speaker Scale. Results indicated that all measures of anxiety correlated positively with the tendency to think irrationally.

In summary, research data employing children, college volunteers and mental health professionals support the hypothesis that there is a positive correlation between endorsement of irrational beliefs and psychopathology.

RET Outcome Studies

There have been a large number of studies done supporting the efficacy of RET as a treatment approach. Along with case study reports (Ellis, 1959) there have been a number of controlled experimental studies (Trexler & Karst, 1972; Meichenbaum, Gilmore & Fedoravicus, 1971). In a paper presented at a meeting of the Society for

Psychotherapy Research, Glass and Smith (1980) reported data supporting the relative effectivenss of RET. They examined 375 psychotherapy outcome studies, 35 of which were rational emotive therapy studies employing control groups. The results indicated that rational emotive therapy ranked second to systematic desensitization, among the 10 forms of psychotherapy in producing significantly greater treatment gains than control groups.

Non-Comparative Outcome Studies

The studies reviewed in this section generally do not compare RET with other types of psychotherapy in a controlled manner. As well, these studies primarily utilized college volunteers for subjects. These studies largely deal with the reduction of anxiety and stress in public speaking, therefore the applicability and generalizability of their findings to a clinical population remains somewhat in doubt.

Karst and Trexler (1970) compared the effects of RET, Kelly's fixed role theory and no therapy in the treatment of public speaking anxiety in college students. Twenty-two volunteers were randomly assigned to one of the three groups, and were pre and post tested on five self-report and two behavioral measures. Three measures showed both therapies significantly more effective than no therapy; and a fourth approached statistical significance.

Sharma (1970) applied RET in a group setting, using anxious high school underachievers as subjects. Students were assigned to one of four groups: Group A received rational group therapy; students in Group B were taught rational ideas but were not encouraged to relate them to their daily lives; Group C was taught study skills, 50 minutes each week for nine weeks. Group D received no treatment (cited in Vargo, 1972). Pre-post treatment measures were taken of irrational ideas, anxiety and grades. Immediately after the termination of treatment it was found that the underachievers exposed to rational group counseling (Group A) had shown significantly greater reduction in Irrational beliefs than did the underachievers in the control group. Changes in Group A, on the other hand, were not significantly different from the changes in the other groups on test anxiety and on school marks. Five months after the experiment was over, follow-up testing revealed that wherever the situation concerning test anxiety remained unchanged, the rational counseling group showed significantly greater improvement in school marks than did the other three groups.

Trexler and Karst (1972) follow-up to their 1970 study investigated the comparative efficacy of RET, "Attention Placebo" (AP), and No Contact (NC) in reducing public speaking anxiety. The results of pre-therapy to post-therapy changes, as assessed by three observational and four self-reported measures, indicated that RET was

significantly more effective in reducing anxiety than either the AP or NC group. A six month follow-up revealed the improvement had been sustained in favor of the RET treatment.

Straatmeyer and Watkins (1974) conducted an experiment studying the reduction of speech anxiety which partly replicated the Trexler and Karst 1972 project. Fifty-seven college volunteers with self-reported speech anxiety were randomly assigned to one of four groups: (1) complete RET; (2) RET without the disputing component (subjects were given insight into irrational beliefs but received no assistance in challenging these beliefs); (3) Attention placebo group focusing on anxiety in general; and (4) no treatment group. The results, measured by pre-to-post treatment mean change scores, indicated that those receiving RET showed a significant decrease in anxiety.

Wine (1971) investigated the relative contribution of separate components of RET. Subjects were assigned to one of two treatment groups. One group included the additional component of modeling and behavior rehearsal of appropriate self-statements. Wine concluded that a Rational Emotive approach with the addition of modeling and behavior rehearsal was effective in minimizing test anxiety.

In summary, these non-comparative studies generally indicated that RET can be effective in reducing levels of anxiety. The fact that a very large number of the subjects in these studies were college volunteers limits the external

validity of the research.

Comparative Outcome Studies

The studies reviewed in this section, once again primarily deal with the efficacy of RET in reducing interpersonal anxiety, using a student population as subjects. However, these studies compare RET with other psychotherapies in order to determine which is most beneficial.

DiLoretto (1970) conducted a study investigating the relative effectiveness of RET, systematic desensitization and client-centered therapy for the reduction of interpersonal anxiety with introverts and extroverts. The study used 100 freshman and sophomores enrolled in an introductory psychology course. His results suggested that all three treatment conditions differed significantly from the attention placebo and no control group on all dependent measures. RET was more effective in reducing anxiety with introverts than was client-centered treatment. A three-month follow-up indicated that those students in the RET group reported more change in behavior than did those in the other treatment groups. Ellis (DiLoretto, 1971) in his criticism of DiLoretto's study mentioned that the therapists utilized a "watered down" version of RET. Ellis stated that the therapists were generally too didactic, and did not put sufficient emphasis on the need to practice what had been learned.

Meichenbaum (1972) studied the relative effectiveness of group cognitive modification, group systematic desensitization, and a waiting list control, on the reduction of test anxiety. The cognitive modification group received treatment consisting of two components. The first aspect, was a cognitive approach derived from RET; the second component was a modified desensitization procedure which utilized a coping imagery and relaxation strategy. The results indicated that the cognitive modification group based on RET produced greater improvement than did the desensitization and control conditions. The superiority of the cognitive modification treatment was maintained at a one-month follow up.

Wolfe (1975) used the cognitive component of RET as an adjunct to other methods of treating nonassertive behavior. She compared modeling plus behavior rehearsal, modeling plus behavior rehearsal plus rational therapy, a placebo group and a no-treatment group. She randomly assigned 64 women into one of four groups. The modeling plus behavior rehearsal group observed the experimenter model the appropriate assertive response and then they rehearsed. The modeling plus behavior rehearsal plus rational therapy group included RET cognitive concepts which included identifying and disputing irrational beliefs. The placebo group discussed early socialization experiences behind non-assertiveness. The no-treatment control group was a waiting list control. The results indicated that both

treatment groups showed significantly more improvement on measures of assertion than the controls. On the measure of situational anxiety, the modeling plus behavior rehearsal plus rational therapy group was significantly better than the other three groups.

Moleski and Tosi (1976) conducted the first RET study with an actual clinical population. They examined the comparative efficacy of RET and systematic desensitization in the treatment of stuttering. Twenty clinical patients randomly assigned to the treatment conditions served as subjects. Also included were a no-treatment control group and two treatment groups with behavioral homework assignments. RET was found to be more effective than desensitization in reducing stuttering, anxiety and negative attitudes with respect to stuttering.

Carmody (1977) examined the relative effectiveness of Rational Emotive Assertion Training, Behavioral Assertion Training and a waiting list control group. On a self-report measure of assertiveness and anxiety, the three treatment groups were not significantly different. The Behavioral Assertion Group did not manifest significantly more behavior changes in assertiveness than the other two treatment groups. However, the Rational Emotive Assertion Training group was the only group that did significantly better on an *in vivo* test of transfer of treatment effects.

Lipsky, Kassinove and Miller (1980) conducted the first study attempting to demonstrate the efficacy of rational

emotive therapy with a population of multisymptomatic applicants to a community mental health center. Specifically, the effectiveness of rational emotive therapy alone, or in combination with rational emotive imagery or rational role reversal was assessed. Rational emotive imagery is a cognitive procedure similar to systematic rational restructuring wherein the subject is instructed to cope with an anxiety-provoking image by identifying irrational beliefs and then emitting more rational, anxiety-incompatible cognitions.

In the Lipsky et al. (1980) study, 50 adult male and female outpatients aged 21 - 60 years, were assigned to three rational emotive therapy conditions, an alternative treatment control group receiving relaxation training and supportive therapy, and a no-contact control group. Two trained therapists conducted 45 minute individual sessions once a week for a total of 12 weeks. Dependent variables included measures of rational thinking, anxiety, depression and neuroticism. Their results indicated that on each dependent variable rational emotive therapy, either alone, or in combination with rational emotive imagery, or rationale role reversal, was more effective than relaxation training, and support or no contact.

Their study is important for a number of reasons. It provides support for the efficacy of RET with a clinical population suffering from a variety of anxiety and adjustment disorders. As such, the results are more

relevant to a clinical setting than previous analog data with college subjects.

Pitkow (1980) conducted a study to investigate the effectiveness of RET with clinical outpatients using rational emotive bibliotherapy. His sample consisted of 41 adults (5 males and 36 females, aged 20-55) who applied for psychotherapy at an outpatient mental health center. Applicants were assessed during a 45 minute intake interview with a member of the staff. This was followed by a disposition staff conference where diagnosis and recommendations were decided upon. Those patients who were accepted were assigned to one of the four treatment conditions based on individual therapist caseload and group availability. The four treatment groups were: rational emotive therapy (n=9); rational emotive thearapy plus rational emotive bibliotherapy (n=15); rational emotive therapy plus placebo bibliotherapy(n=11); and psychodynamic psychotherapy (n=6). The test instruments used were: the Multiple Affect Adjective Checklist, Idea Inventory (Kassinove, Crisci, & Tiegerman,1977), State-Trait Anxiety Inventory (Spielberger, Gorsuch, & Lushene, 1970) and Eysenck Personality Scale (Eysenck, 1968). The author hypothesized that: (1) subjects in the rational emotive therapy plus rational emotive bibliotherapy group would do significantly better than subjects in all other treatment groups on the measure of content acquistion and on each measure of emotional adjustment; (2) subjects in each of the

three rational emotive therapy groups would do significantly better than subjects in the psychodynamically-oriented psychotherapy group on the measure of content acquistion and on each measure of reported emotional adjustment; and (3) there would be a significant interaction between the passage of time and treatment. The results did not provide statistical support for any of the above hypotheses. Subjects receiving rational emotive therapy plus rational emotive bibliotherapy did not differ significantly from those in the other treatment conditions on any of the dependent measures. Subjects in each of the three rational emotive therapy treatment groups did not differ significantly from those in psychodynamically-oriented psychotherapy on any dependent measure. The author accounted for these findings by discussing such variables as therapist motivation and expertise, sample size and adjunctive bibliotherapy.

Summary of Outcome Research

Mahoney (1974) and Meichenbaum (1977) in their respective surveys of cognitive therapy literature, concurred that the clinical efficacy of rational emotive therapy has not been verified. Ledwidge (1978) commented on the lack of empirical support in clinical settings. However, the results of more recent investigations suggest that employing rational emotive therapy is more effective than no treatment and nonspecific treatment in treating both

circumscribed and generalized emotional disorders.

CHAPTER 3

METHODOLOGY

Procedure

Based on his own study, Vargo (1972) stated: "Given that a person grows psychologically as a consequence of therapy, he becomes more mentally healthy. But does he also become more rational?" (pp. 65-66). As well, he argued that his results suggest that all rational people are assertive.

The purpose of this study was to expand on Vargo's work and focus on some of the issues developed by his findings with a clinical population. Specifically, it was designed with psychiatric outpatients in a day therapy program. The study looked at such questions as:

1. Was there an increase in rationality as measured by the Irrational Beliefs Inventory for those subjects receiving RET?
2. Did the teaching of RET principles increase the likelihood of responding assertively?
3. Was RET more effective in reducing levels of overt, covert and total anxiety when compared to a non-structured therapy approach and a no-therapy control?

Sample

First Treatment Group

The Rational Emotive Therapy treatment group was comprised of 10 outpatients receiving psychiatric care. (Admission criteria to the Day Therapy program are included in Appendix F) The patients for the RET group were randomly chosen from the day therapy population. This group met for three one-hour sessions per week over a four week period.

RET group procedures

Sessions 1 and 2 - During the first two sessions patients were presented with handouts (Appendices D and E) on RET principles and interogation techniques as well as a list of irrational ideas and mistaken beliefs. All the handouts were discussed in detail with particular emphasis on explaining Ellis's ABC model of change. Each patient was asked to read out loud one of the irrational ideas and then the group members gave examples of where these irrational ideas may have led to negative consequences. Each example was examined in the context of the ABC model which was written on the blackboard. During the end of each session a homework assignment was given. For the first two sessions this involved having each patient think about a problem that was of concern and what irrational beliefs might be involved. These problems were then brought up for analysis in the next RET group session.

Sessions 3,4 and 5 involved five patients presenting problems. These sessions were primarily directed by the two therapists and involved didactic work. Specifically, the ABC model was put on the blackboard and the activating event and consequences presented by the patient were analyzed. All patient were encouraged to generate examples of the kinds of irrational beliefs and self-statements that they were making with respect to a problem and the ways these beliefs could be challenged and the consequences altered. The final part of therapy process (sessions 6 through 12) involved encouraging the group to develop alternative rational self-statements and to make suggestions to the individuals in the group who presented particular issues. Through the use of role-playing, visual imagery and direct challenging patients were assisted to look at those beliefs and attitudes that may have contributed to maintaining their problems.

Second Treatment Group

Eleven patients randomly chosen from those attending day therapy but not the RET group constituted the second treatment group. They were assigned to the "Community Group." The purpose of the Community group was to give those patients not attending the RET group an opportunity to meet together to talk about whatever issues they wished. The one hour sessions were spent discussing very general topics, such as sports, politics and fashions etc. There

was no structured agenda. The two therapists were there to facilitate discussion and encourage participation among group members. (The groups which are available in the day therapy program, excluding the RET group, are described in Appendix F).

No-Treatment Control Group

The no-treatment control group consisted of 10 hospital employees, excluding medical personnel and other therapists in the day therapy program. The controls were randomly chosen for the study from the Departments of Social Work, Psychology, Support Services and Nursing, following a self-report of good physical and emotional well-being. The purpose of this group was to control for the effects of time and testing. It was assumed that sampling from these various departments would increase the statistical validity of the sample, rendering it more comparable to the general non-psychiatric population.

Instrumentation

Adult Irrational Ideas Inventory

The 60 item Adult Irrational Ideas Inventory (AII), is based on the Irrational Ideas Inventory developed by Zingle (1965) to measure the extent to which high school students exhibited the eleven irrational beliefs outlined by Ellis.

The items of the instrument are single statements scored on a five-point Likert scale ranging from "strongly agree" to "strongly disagree". Scoring consists of allocating a weight of one to the most rational choice. Thus, a high score represents a greater degree of irrational thinking.

Reliability

A test-retest reliability on 110 senior education students over a three week period yielded a Pearson correlation coefficient of .76. A Kuder-Richardson formula 20 resulted in coefficients of .74 and .78 (Zingle, 1965).

Validity

Construct validity of the AII inventory has been established by Conklin (1965), Zingle (1965), and Taft (1968). Studies with this scale have a reported a positive relationship between irrationality and anxiety (Taft, 1968; Winship, 1972) , assertive behavior (Vargo, 1972) and underachievement (Conklin, 1965; Zingle, 1965). (See Appendix A)

IPAT Anxiety Scale Questionaire

The IPAT Anxiety Scale was developed from extensive research and practice as a means of collecting clinical anxiety information rapidly, and objectively, using a standard format. It is a brief, non-stressful, clinically valid questionnaire for measuring anxiety, applicable to all

but the lowest educational levels and appropriate for ages 14 or 15 through the adult range. The scale provides an accurate appraisal of free-floating anxiety level, supplementing clinical diagnosis and thereby facilitating research endeavours where little assessment time can be spent.

The test is easily administered individually or to large groups and can be self-administered. The IPAT Anxiety Scale consists of 40 questions distributed among the five anxiety-measuring factors. Three kinds of scores are possible: A single total anxiety score based on all 40 items is all that is required in the majority of cases (IPAT Handbook). The two remaining scores are derived from a breakdown into an unrealized, covert "cryptic question" anxiety score, "A", for the 20 items on the left-hand test page; and an overt, symptomatic, conscious anxiety score, "B", for the 20 right-hand page items. When used seperately, these scores can be presented for interpretation, as a ratio of overt to cryptic anxiety (Score B/Score A).

Validity

Construct Validity is estimated at between .85 and .90 for the total scale. This is derived from the correlation of the test items and components with the anxiety factor. The average correlation between individual items and total test

score was almost .40 with no cases of inconsistent direction of relation, and the multiple correlation between all items and the total score exceeding .92. (IPAT Anxiety Handbook).

The reliability test-retest (one-week interval) was .93, the test-retest (two-week interval) was .93 and the homogeneity split-half was .91.

Gambrill and Richey's Assertion Inventory

The Gambrill and Richey Assertion Inventory is a 40-item self-report inventory which permits respondents to note for each item their degree of discomfort, their probability of engaging in the behavior, and situations they would like to handle more assertively. The Assertion Inventory was normed on a university undergraduate population, 388 women and 269 men, who ranged in age from 18 to 27 years (Gambrill & Richey, 1975). Test-retest reliability was reported at .81 for response probability and .87 for discomfort. Buff (1978) conducted a reliability, validity and factor analytic study of the Assertion Inventory and found the test-retest correlations were significant. The response probabilitiy subscale of the Assertion Inventory was found to correlate significantly with the Adult Self-Expression Scale, another assertive inventory. Gambrill and Richey (1975) reported that the assertive situational items fell into eight categories:

1. turning down requests,
2. expressing personal limitations,

3. initiating social contracts,
4. expressing positive feelings,
5. handling criticism,
6. differing with others,
7. assertion in service situations, and
8. giving negative feeback.

The items are answered on a Likert-type scale of 1 to 5. Each item of the test lists a situation such as "Turn off a talkative friend." An answer of 1 means always do it; 2, usually do it; 3, do it about half the time; 4, rarely do it; 5, never do it. The score for each subject was determined by adding the 40 response probabilities. The lower the score the more assertive are the subject's responses.

Statistical Hypotheses

This chapter presents the hypothesis and the results of the statistical analysis related to them.

1. Irrationality

Those subjects in the day therapy program at the Edmonton General Hospital taking part in the RET group will show a greater reduction of the number of irrational beliefs endorsed as measured by the Adult Irrational Ideas Inventory than subjects not taking RET but in the day therapy program, and the no-treatment control group.

2. **Assertiveness**

Those subjects in the RET group will show a greater increase in the number of assertive behaviors endorsed, as measured by the Gambrill & Richey Assertive Inventory, than those subjects in day therapy but not taking RET, and the no-treatment control group.

3. **Anxiety**

Those subjects receiving RET will show a greater reduction of overt, covert and total anxiety as measured by the IPAT Anxiety Scale, than those individuals in day therapy not receiving RET and the no-treatment control group.

Statistical Treatment

Data were gathered through the use of the three self-report measures outlined above. Total scores of irrational beliefs, overt, covert, total anxiety and assertiveness were obtained on a pre- and posttest basis for all subjects.

In order to test the four hypotheses in question, a two-way analysis of variance (ANOVA) with repeated measures on one factor was utilized. One ANOVA was conducted for each of the five dependent variables (Adult Irrational Ideas Inventory, Gambrill & Richey Assertive Inventory, IPAT Anxiety Scale). In addition, Scheffe post-hoc comparison

tests were used to further examine statistically significant ANOVA results. The level of significance of each hypothesis tested was set at the .01 level.

CHAPTER 4

Results

The data gathered from pre-treatment and post-treatment administrations of the instruments used in this study were subjected to statistical analysis in an effort to determine the tenability of the hypothesis. There are three treatment conditions and two levels of time. The three treatment conditions are: (1) Experimental Group 1 - Rational Emotive Therapy Group. Individual in this group received Rational Emotive Therapy in the cognitive therapy group while attending Day therapy. (2) Experimental Group 2 - No-RET Community Group, those individuals in day therapy not receiving RET were assigned to the Community Group. (3) Group 3 - Control. This group of people were randomly chosen from hospital personnel at Edmonton General Hospital.

The effect of time was investigated by administering the dependent measures on two occasions. (1) Pretest - immediately preceeding the first therapy session in the case of the two experimentals, and on the same day to the individual in the control group. (2) Posttesting - immediately following the twelth therapy session.

Five dependent measures were utilized:

1. IPAT anxiety scale - overt measure.
2. IPAT anxiety scale - covert measure.

3. IPAT anxiety scale - total anxiety measure.
4. Irrational Ideas Inventory.
5. Gambrill and Richey Assertiveness Inventory.

Hypotheses tested

Hypothesis I - On the IPAT anxiety scale - overt measure, the change from pretesting to posttesting for the subjects receiving RET will be significantly different from the changes in scores of the subjects receiving No-RET Community Group, or from the no-treatment control group.

This hypothesis was tested using a two-way analysis of variance with repeated measures and Scheffe post-hoc comparison tests. The means and standard deviations from pretest to posttest are included in Table I. Higher scores indicate higher levels of overt anxiety.

The interaction effects were examined to locate the source of the differences, Table II and III present the results. Table II indicates that the differences occurred across both time and group. Scheffe tests were used to determine which groups were significantly different from the others. Table III indicates that the RET group and the non-RET community group were both statistically different from the control. Table III indicates that the differences between group 1 and group 2 were not significant at the .01 level.

Table I

Pretest and Posttest Means for the RET group, the Non-RET Community Group and the Control Group on the IPAT anxiety scale - Overt measure

Group	Pretest Mean	S.D.	Posttest Mean	S.D.
RET Group(1)	25.444	4.053	20.778	4.549
No-RET Community Group(2)	22.111	4.833	20.000	5.220
Control Group	15.000	3.041	13.001	4.215

Table II

Pretest and Posttest Scores for the RET group, the Exp. Non-RET Group and the Control Group on IPAT Anxiety Scale - Overt measure

Source	Sum of Squares	Degrees of Freedom	Mean Square	Probability
A-Group	822.111	2	411.056	
S-Within,	865.227	24	36.051	.001
B-Test	115.574	1	33.241	.001
AB	20.481	2	2.945	.072
BS Within	83.445	24		

Table III

Overt Anxiety - Scheffe Comparisons of Unweighted Main Effects

	I	J	F Ratio	Probability
Group	1	2	0.527	0.597
Group	1	3	10.362	0.001
Group	2	3	6.214	0.007

Hypothesis II - On the IPAT anxiety scale covert measure the change in scores from pretesting to posttesting for the subjects receiving RET will be significantly different from that of the Non-RET Community Group, and the Control Group. Once again, the higher the mean score the higher the level of covert anxiety.

The interaction effects were examined to determine the source of the difference. To achieve this Scheffe tests were utilized. Tables V and VI indicate that the significant decrease in overt anxiety from pretesting to posttesting occurred within the RET group and the Non-RET community group but not in the control group.

Hypothesis III - On the IPAT anxiety scale - total anxiety measure, the changes in scores from pretesting to posttesting for the subjects receiving RET will be significantly different from those of the Non-RET Community group or from the trend of the Control Group.

The interaction effects were examined to determine the source of the differences. Scheffe tests were utilized for this purpose. Table VII indicates that the significant decrease in total anxiety from pretesting to posttesting occurred within the RET group and the Non-RET community group but not in the Control group. Tables VII, VIII and IX indicate that the difference between the RET group and Non-RET Community group was not significant at the .01 level.

Table IV

Pretest and Posttest Means for the RET group, the Experimental Non-RET Group, and the Control Group on the IPAT anxiety scale - Covert measure

Group	Pretest Mean	S.D.	Posttest Mean	S.D.
RET Group(1)	29.778	5.286	24.667	7.665
Experimental Non Ret Group(2)	28.222	3.563	25.667	3.841
Control Group(3)	8.889	2.848	9.222	1.641

Table V

Pretest and Posttest Scores for the RET group, the Exp. Non-RET Group and the Control Group on IPAT Anxiety Scale - Covert measure

Source	Sum of Squares	Degrees of Freedom	Mean Square	Probability
A-Group	3900.705	2	1950.352	0.001
S-Within	736.004	24	30.667	
B	80.666	1	80.666	0.012
AB	66.777	2	33.389	0.067
BS Within	263.559	24	10.982	

Table VI

Covert Anxiety - Scheffe Comparisons of Unweighted Main Effects

	I	J	F Ratio	Probability
Group	1	2	0.011	0.989
Group	1	3	48.428	0.000
Group	2	3	46.958	0.000

Table VII

Pretest and Posttest Means for the RET group, the Experimental Non-RET Group, and the Control Group on the IPAT anxiety scale - total anxiety measure

Group	Pretest Mean	S.D.	Posttest Mean	S.D.
RET Group	55.222	7.949	45.444	10.702
Experimental Non RET Group	50.333	3.240	45.667	4.924
Control Group	23.889	5.231	22.222	4.658

Table VIII

Pretest and Posttest Scores for the RET group, the Exp. Non-RET Group and the Control Group on IPAT Anxiety Scale - total anxiety measure

Source	Sum of Squares	Degrees of Freedom	Mean Square	Probability
A-Group	8230.465	2	4115.230	0.001
S-Within	1679.500	24	69.979	
B	389.355	1	389.355	0.001
AB	151.383	2	75.691	0.024
BS Within	412.813	24	17.201	

Table IX

Total Anxiety - Scheffe Comparisons of Unweighted Main Effects

	I	J	F Ratio	Probability
Group	1	2	0.350	0.708
Group	1	3	47.848	0.000
Group	2	3	40.012	0.000

Hypothesis IV - On the Irrational Beliefs Inventory, the change in scores from pretesting to posttesting for the subjects receiving RET will be significantly different from those from the Non-RET Community Group or from the Control Group. Higher scores indicate a higher number of irrational beliefs being endorsed.

The interaction effects were analyzed to locate the source of possible differences. Table XII indicates that the significant increase in rational beliefs (decreased scores) from pretesting to posttesting occurred within the RET group and the Non-RET Community Group but not in the control group. Table X indicates that the greatest reduction in irrational beliefs chosen occurred within the Community Group.

Hypothesis V - The Gambrill-Richey Assertiveness Inventory the trend from pretesting to posttesting for the subjects receiving RET will be significantly different from the trend of the No-RET Community group or from the Control group. The higher the score attained the less assertive the individual is hypothesized to be.

Significant interaction was found between the two variables of treatment and testing. This interaction indicates that the groups were statistically different on the trend from pretesting to posttesting, therefore hypotheses V was rejected.

Table X

Pretest and Posttest Means for the RET group, the Experimental Non-RET Group, and the Control Group on the Irrational Beliefs Inventory

Group	Pretest Mean	S.D.	Posttest Mean	S.D.
RET Group(1)	192.778	33.462	173.111	18.079
Non-RET Group(2)	198.222	45.196	173.334	13.720
Control Group(3)	141.889	10.301	145.000	9.124

Table XI

Pretest and Posttest Scores for the RET group, the Clinical Non-RET Group and the Control Group on the Irrational Beliefs Inventory

Source	Sum of Squares	Degrees of Freedom	Mean Square	Probability
A-Group	20162.25	2	10081.125	0.001
S-Within	16339.00	24	680.792	
B	2576.250	1	2576.25	0.050
AB	1995.188	2	997.594	0.214
BS Within	14553.000	24	606.375	

Table XII

Irrational Beliefs Inventory - Scheffe Comparisons of Unweighted Main Effects

	I	J	F Ratio	Probability
Group	1	2	0.053	0.948
Group	1	3	10.311	0.001
Group	2	3	11.844	0.000

This interaction permitted an examination of the effects to locate the source of the differences. Table XV indicates that significant increase in assertiveness (decreased assertiveness scores) from pretesting to posttesting occurred within the RET group but not in the Non-RET Community group or in the Control group.

SUMMARY

In regard to overt anxiety as measured by the IPAT Anxiety Scale, the gains from pretesting to posttesting were significant for both the RET group and the Non-RET Community group. The results of the data analysis indicate that both treatment conditions improved with respect to this measure. It appears that both the rational emotive therapy intervention and the approach employed in the community group were effective in reducing overt anxiety.

In regard to covert anxiety as measured by by the IPAT anxiety scale, the significant gain from pretesting to posttesting occurred within the RET group and the non-RET Community group. The data analysis indicated that members of both the RET group and the Community Group manifest significantly decreased covert anxiety.

With respect to total anxiety as measured by the IPAT anxiety scale, the gains from pretesting to posttesting were significant for both the RET group and the Non-RET Community group but not for the Control group. The data analysis indicated that both treatment groups reduced the total level

Table XIII

Pretest and Posttest Means for the RET group, the Clinical Non-RET Group, and the Control Group on Gambill and Richey Assertiveness Inventory

Group	Pretest Mean	S.D.	Posttest Mean	S.D.
RET Group	125.333	7.159	119.667	14.396
Clinical Non RET Group	115.778	10.341	112.667	12.410
Control Group	101.667	8.703	104.44	10.667

Table XIV

Pretest and Posttest Scores for the RET group, the Clinical Non-RET Group and the Control Group on the Gambill-Richey Assertiveness Inventory

Source	Sum of Squares	Degrees of Freedom	Mean Square	Probability
A-Group	3427.875	2	1713.938	0.002
S-Within	5024.688	24	209.362	
B	54.000	1	54.000	0.170
AB	168.750	2	84.375	0.062
BS Within	647.125	24	26.964	

Table XV

Gambrill and Richey Assertive Inventory - Scheffe Comparisons of Unweighted Main Effects

	I	J	F Ratio	Probability
Group	1	2	1.473	0.249
Group	1	3	8.127	0.002
Group	2	3	2.680	0.089

of anxiety as reported by group members.

With respect to irrational beliefs as measured by the Irrational Beliefs Inventory, the significant change from pretesting to posttesting occurred within both the RET Group and the No-RET Community Group and not within the Community Group.

In regard to assertiveness as measured by the Gambrill and Richey Assertiveness Inventory, the increase in assertiveness from pretesting to posttesting was significant only for the RET group. The results of the data analysis indicate that the members of the RET group were significantly more likely to make an assertive response than were members of the Community or Control group.

In summation, it would seem that the therapy received by the RET group was generally no more effective than the therapy received by the no-RET Community group.

CHAPTER 5

Discussion

The purpose of this study was to investigate the effects of Rational Emotive Therapy on the psychological adjustment of adult patients from a psychiatric day therapy program. The efficacy of RET was compared to a non-directive support therapy group (Community group) and a no-therapy Control group. A total of five dependent measures were used

1. IPAT overt anxiety measure
2. IPAT covert anxiety measure
3. IPAT total anxiety measure
4. Irrational beliefs inventory
5. Gambrill and Richey Assertiveness Inventory.

One of the major purpose of the Rational Emotive Therapy Group involved in the present study was to teach day therapy patients the basic premises and applications of RET. Specifically, the patients learned that a significant component of their emotional and general psychological problems were caused, not by the people or particular circumstances in their environment but by their beliefs and attitudes about those people and events.

The ABC model of emotional disturbance was utilized as a didactic tool to assist group members identify and

challenge irrational unproductive ideas and behaviors and thereby substitute more rational and productive ones. The RET group also made use of various cognitive-emotive homework assignments.

It was hypothesized that the RET group would not do significantly better from pretesting to posttesting on these five measures, than would the individuals in the Community group and the Control group. In general, the results of this study do not statistically support this hypothesis. With regard to the Irrational Ideas Inventory, which was developed as a measure of the introjection and endorsement of Albert Ellis's Irrational Beliefs (Appendix II) there was a statistically significant difference between the RET group and Control Group. However, there was no statistically significant difference between the RET group and the Community Group. This finding may be explained in a number of ways. The fact that there was only 12 sessions of the group over a four week period may not have been a sufficiently long period of time for patients to fully understand and challenge some of their fundamental underlying irrational beliefs. As well, the fact that individuals in both the RET group and the Community group were in day therapy and were receiving information and insight from a number of different perspectives may have reduced the overall impact of the Cognitive group. As well, Ellis argues that all productive forms of psychotherapy reduce irrational thinking, therefore one could hypothesize

that the individuals receiving group therapy in this study have verified to some degree Ellis's argument.

Another tenable explanation for the lack of significant differences between the RET and Community group may be due to the limitations of the therapists conducting the RET group, or the strengths of the therapists leading the Community group. This study utilized a PhD student in educational psychology and a nurse in the RET group, and two nurses in the Community Group. As well, the lack of formal montioring of the consistency, procedures and the content of both therapy groups may have played a role in reducing the overall difference between groups.

The results of the analysis of responses with respect to overt, covert, and total anxiety as measured by the IPAT anxiety scales indicate that the RET and the Community group were equally effective in reducing the level of anxiety as determined by change in pretest to posttest mean scores. However, the fact that the difference between the mean scores of the RET group and the Community group was not statistically significant may once again be explained by the limited time frame of the groups, and the relative effectiveness of the therapists.

The results of the data from the Gambrill and Richey Assertiveness scale indicate that the RET group was the most effective in increasing the probability of eliciting an assertive response. Lazarus (1975) pointed out the importance of cognitive factors on behaviors and emotions.

He suggested that coping behaviors may best be achieved by correcting cognitive processes first. The results of this study support the argument that cognitive-mediating functions are important with respect to human emotion, behaivors and increasing the likelihood of "positive" responses.

Implications for Future Study

The aims or goals of counseling stated by Ellis are similar to those of most other counselors and psychotherapists. Ellis has written about the reduction and virtual elimination of inadequacy, anxiety, depression, and the need to strive for rational behavior and self-actualization. What is clearly different however, are the methods used to bring about change and the assumptions underlying RET theory. Effective therapy is seen as bringing about changes in attitudes and beliefs and because many of these attitudes are long-standing and strongly held they need to be confronted directly and strenuously. A number of researchers (Goldfried & Davison, 1976) have argued that having the clients come to understand and challenge their own beliefs may be a more effective method of bringing about long lasting change than having it imposed by a therapist. Further research into possible alternative strategies using the basic RET framework would be beneficial.

Having used RET over an extended period with a variety of clients, particularly in a psychiatric setting, it has been my experience that Ellis does not emphasize enough the importance of establishing a solid therapeutic relationship with the client. It is only when a relationship has been developed and trust established that many clients are willing to risk self-disclosure. This is particularly evident, I believe with the use of RET which is didactic and often involves challenging fundamental beliefs. Research into the similarities and differences in the perception of the relationship between therapist and client, studying for example RET as compared to behavioral approaches, or client-centered therapy may provide useful data in assessing the importance of the therapeutic relationship using a variety of approaches.

Another aspect of RET that would benefit from further study involves Ellis's eleven central ideas or values that he sees as universal to western society (Ellis, 1962a). As is clearly evident, he acknowledges that these basic irrational ideas are only applicable to western culture. Non-western cross cultural studies would provide a wealth of new information with regard to the validity of Ellis's theoretical framework. Does the ABC model of psychological disturbance apply to other cultures? Is it possible to identify universal irrational beliefs that transcend cultural boundaries? Are the consequences of adopting irrational beliefs similar or different in non-western

cultures? Would more emphasis on the philosophical aspects of RET be more or less effective than the highly didactic approach utilized in the West. Ellis does not effectively deal with the issue of the cultural bias of his model as it is currently set out.

More research is needed to investigate the extent to which the changes that take place with RET are actually integrated into an individual's repertoire of behavior over an extended period. Does the cognitive orientation of a person affect the degree to which a person internalizes RET principles? Another research area could explore alternate methods of presenting RET in order to determine which is the most effective. Additionally an investigation of varying the length of time of RET groups would be beneficial in order to assess the optimal length for effective outcome. Conducting a six month follow-up in order to determine the degree to which changes in level of anxiety, assertiveness etc. were maintained after therapy was complete, would be beneficial.

It would be valuable in future outcome studies with RET to continue to use a clinical population in order to more accurately assess the generalizability of these findings. AS well, it also may be useful to vary the presentation of the RET group. For example, more role-playing , a closer monitoring of the therapeutic interventions, and training of the therapists may provide useful information. Increasing the size of the sample population may also enhance the

probability of obtaining significant results.

Summary and Recommendations

This study represents one of the very few RET outcome studies utilizing a psychiatric population with a control group. It attempted to compare the efficacy of RET with a non-structured community group and a no-therapy control group. The results strongly indicate that RET was effective in reducing anxiety and irrational thinking and improving the probability of making an assertive response.

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APPENDIX A - Adult Irrational Ideas Inventory

Read each of the following statements and decide how much you agree or disagree. Show your answer on the seperate answer sheet. Use the code shown below.

A. I Strongly Agree
B. I Agree
C. Undecided
D. I Disagree
E. I Strongly Disagree

NOTE

Answer *All* the questions (Mark only one choice for each question).
There are no right or wrong answers.
There is no time limit.
If you wish to change an answer, be certain to erase the undesired answer completely.
Because the inventory is to be machine scored a soft pencil should be used.

1. Jeers humiliate me even when I know I am right.
2. I worry about situations where I am being tested.
3. The best way to teach a child right from wrong is to spank him when he is wrong.
4. I must learn to "keep my head" when things go wrong.
5. I think I am getting a fair deal in life.
6. I worry about eternity.
7. I am happiest when I am sitting around doing little or nothing.
8. I prefer to be independent of others in making decisions.
9. If a person is ill-tempered and moody, he will probably never change.
10. . I get very upset when I hear of people (not close relatives or close friend) who are very ill.
11. Crime never pays.
12. My family and close friends do not take enough time to become acquainted with my problems
13. People who do not achieve competency in at least one area are worthless.
14. We are justified in refusing to forgive our enemies.
15. I frequently feel unhappy with my appearance.
16. 16. I feel that life has a great deal more happiness than trouble.
17. I worry over possible misfortunes.
18. I often spend more time in trying to think of ways of getting out of something than it would take me to do it.

19. I tend to look to others for the kind of behavior they approve as right and wrong.
20. Some people are dull and unimaginative because of defective training as a child.
21. Helping others is the very basis of life.
22. School promotions should be for intellectual merit alone.
23. It is very important to me when I do a good job to be praised.
24. I find it difficult to take criticism without feeling hurt.
24. It is terribly upsetting the way some students seem to be constantly protesting about one thing or another.
25. It is impossible at any given time to change one's emotions.
26. I tend to worry about possible accidents and disasters.
27. I need to learn how to keep from being too assertive or too bold.
28. To cooperate with others is better than doing what you feel should be done.
29. Sympathy is the most beautiful emotion of man.
30. People who criticize the government are either ignorant or foolish
31. I wish more affection were shown by members of my family.
32. When a person is no longer interested in doing his best, he is done for.

33. I get very angry when I miss a bus which passes only a few feet away from me.
34. My place of employment and/or my neighborhood provide adequate opportunity for me to meet and make friends.
35. I can walk past a grave yard alone at night without feeling uneasy.
36. I avoid inviting others to my home because it is not as nice as theirs.
37. I prefer to have someone with me when I receive bad news.
38. It is necessary to be especially friendly to new co-workers and neighbors.
39. The good person is usually right.
40. Sometimes I feel that no one loves me.
41. I worry about little things.
42. Riches are a sure basis for happiness in the home.
43. I can face a difficult task without fear.
44. I usually try to avoid doing chores which I dislike doing.
45. I like to bear responsibilites alone.
46. Other peoples' problems frequently cause me great concern.
47. It is sinful to doubt the bible.
48. It makes me very uncomfortable to be different.
49. I get terribly upset and miserable when things are not the way I would like them to be.
50. I find my occupation and social life tends to make me

unhappy.

51. I am afraid in the dark.
52. Many people that I know are so unkind or unfriendly that I avoid them.
53. It is better to take risks and to commit possible errors, than to seek unecessary aid from others.
54. I get disturbed when neighbours are very harsh with their little children.
55. I find it very upsetting when important people are indifferent to me
56. I have sometimes had a nickname which upset me.
57. I have sometimes crossed the street to avoid meeting some person.
58. When a friend ignores me I become extremely upset.
59. My feelings are easily hurt.

Appendix B - IPAT Anxiety Scale Questionaire - Self-Analysis Form

DIRECTIONS: Inside this booklet you will find forty questions, dealing with difficulities that most people experience at one time or another. It will help alot in self-understanding if you check YES, NO, etc., to each, frankly and truthfully, to describe any problems you may have.

Example:

1. I enjoy walking ..... Yes, Occasionally, No

2. I would rather spend an evening ....

(A) talking to People, (B) at a movie ..... A, In Between, B

1. I find that my interests in people and amusements tend to change very rapidly.

2. If people think poorly of me I can still go on quite serenely in my own mind.

3. I like to wait till I am sure that what I am saying is correct, before I put forward an argument.

4. I am inclined to let my actions get swayed by feelings of jealousy.

5. If I had my life to live over again I would: (A)plan very differently, (B)want it the same

6. I admire my parents in all important matters.

7. I find it hard to "take no" for an answer, even when I know what I ask is impossible.

8. I doubt the honesty of people who are more friendly than I would naturally expect them to be.

9. In demanding and enforcing obedience my parents (or guardians) were: (A)always very reasonable, (b) often unreasonable.

10. I need my friends more than they seem to need me.

11. I feel sure that I could "pull myself together" to deal with an emergency.

12. As a child I was afraid in the dark.

13. People sometimes tell me that I show my excitement in voice and manner too obviously.

14. If people take advantage of my friendliness I: (A)soon forget and forgive, (B) resent it and hold it against them

15. I find myself upset rather than helped by the kind of

personal criticism that many people make.

16. Often I get angry with people too quickly.

17. I feel restless as if I want something but do not know what to do about it.

18. I sometimes doubt whether people I am talking to are really interested in what I am saying.

19. I have always been free from any vague feeling of ill-health, such as obscure pains, digestive upsets , awareness of heart action etc.

20. In discussion with some people I get so annoyed that I can hardly trust myself to speak.

21. Through getting tense I use up more energy than most people in getting things done.

22. I make a point of not being absent-minded or forgetful of details.

23. However difficult and unpleasant the obstacles, I always stick to my original intentions.

24. I tend to get over-excited and"rattled" in upsetting situations.

25. I occasionally have vivid dreams that disturb my sleep.

26. I always have enough energy when faced with difficulties.

27. I sometimes feel compelled to count things for no particular purpose

28. Most people are a little queer mentally, though they do not like to admit it.

29. If I make an awkward social mistake I can soon forget

it.

30. I feel grouchy and just do not want to see people: (A)occasionally, (B)rather often.

31. I am brought almost to tears by having things go wrong.

32. In the midst of social groups I am nevertheless sometimes overcome by feelings of loneliness and worthlessness.

33. I wake in the night and, through worry, have some difficulty in sleeping again.

34. My spirits generally stay high no matter how many troubles I meet.

35. I sometimes get feelings of guilt or remorse over quite small matters.

36. My nerves get on edge so that certain sounds, e.g., a screechy hinge, are unbearable and give me the shivers.

37. If something badly upsets me I generally calm down again quite quickly .

38. I tend to tremble or perspire when I think of a difficult task ahead .

39. I usually fall asleep quickly, in a few minutes, when I go to bed.

40. I sometimes get in a state of tension or turmoil as I think over my recent concerns and interests.

Appendix C - Gambrill & Richey Assertion Inventory

Many people experience difficulty in handling interpersonal situations requiring them to assert themselves in some way, for example, turning down a request, asking a favor, giving someone a compliment, or expressing disapproval or approval. Please indicate your degree of discomfort or anxiety in the space provided *before* each situation listed below. Utilize the following scale to indicate the degree of discomfort:

1 = None
2 = a little
3 = a fair amount
4 = much
5 = very much

Then, go over the list a second time and indicate *after* each item the probability or likelihood of your displaying the behavior if actually presented with the situation. For example, if you rarely apologize when you are at fault, you would mark "4" after the item. Utilize the following scale to indicate response probability:

1 = always do it
2 = usually do it
3 = do it about half the time

4 = rarely do it

5 = never do it.

It is important to cover your discomfort ratings (located in front of the items) while indicating response probability. Otherwise, one rating may contaminate the other and a realistic assessment of your behavior is unlikely. To correct for this, place a piece of paper over your discomfort ratings while responding to the situations the second time for response probability.

Situation

1. Turn down a request to borrow your car.
2. Compliment a friend.
3. Ask a favor of someone.
4. Resist sales pressure.
5. Apologize when you are at fault.
6. Turn down a request for a meeting or date.
7. Admit fear and request consideration.
8. Tell a person who you are initimately involved with when he/she says or does something that bothers you.
9. Ask for a raise.
10. Admit ignorance in some area.
11. Turn down a request to borrow money.
12. Ask personal questions.
13. Turn off a talkative friend.
14. Ask for constructive criticism.
15. Initiate a conversation with a stranger.
16. Compliment a person who you are romantically involved with or interested in.
17. Request a meeting or a date with a person.
18. Your initial request for meeting is turned down and you ask the person again at a later time.
19. Admit confusion about a point under discussion and ask for clarification.

20. Apply for a job.

21. Ask whether you have offended someone.

22. Tell someone you like them.

23. Request expected service when such is not forthcoming, for example, in a restaurant.

24. Discuss openly with the person his/her criticism of your behavior.

25. Return defective items, eg. store or restaurant.

26. Express an opinion that differs from that of the person you are talking to.

27. Resist sexual overtures when you are not interested.

28. Tell the person when you feel he/she has done something that is unfair to you.

29. Accept a date.

30. Tell someone good news about yourself.

31. Resist pressure to drink.

32. Resist a significant person's unfair demand.

33. Quit a job.

34. Resist pressure to "turn on".

35. Discuss openly with the person his/her criticism of your work.

36. Request the return of borrowed items.

37. Receive compliments.

38. Continue to converse with someone who disagrees with you.

39. Tell a friend or someone with whom you work when he/she says or does something that bothers you.

40. Ask a person who is annoying you in a public situation to stop.

Appendix D - RET HOMEWORK EXERCISES

CHALLENGING IRRATIONAL BELIEFS

It is difficult to challenge our irrational beliefs and self-statements. Although much of this work will be done in the group, most of our time is spent outside of the group. These are some suggestions on how you can continue to strengthen your work on your own at home.

Detecting irrational beliefs and self statements.

Keep a daily record for one week of inappropriate self statements. When you feel a change in emotion, stop and look at what you have just been saying to yourself. What do you say when happy?, sad?, bored?, angry?. Write it down. At the end of the week, see if there are constantly recurring negative statements (eg. I'm stupid, It's horrible to be rejected, I must be loved by everyone, if not it is horrible, I am not good enough.)

Challenging beliefs and self-statements.

A) Write down one or two main inappropriate self-statements, eg. *I'm not good enough.* Then write down a list on a card 5-10 challenging statements, eg.

1. There are lots of things I'm good at: paying bills, cooking, being near, being responsible, making friends feel at home etc.

2. Good enough for whom? I do not have to live up to any standards! I'm acceptable as a living human being regardless of what I do!

(B) Keep this card with you and read it to yourself (aloud if you are alone) while looking in the mirror, when you get up, go to bed, and when you are in the bathroom. Do not just read it over, **THINK ABOUT WHAT YOU ARE SAYING.** Do this for at least one week.

(C) Place stickers or bright tape on your clock, wallet and some other place you look at alot. Each time you see the sticker, check yourself for inappropriate and appropriate self-statements. If you have recently made an inappropriate one, challenge it with an appropriate one and give yourself a "pat on the back" for doing so. IF you have just made an appropriate one, *point this out to yourself and congratulate yourself*.

(D) Purposely do something to counter the statement: "I'm stupid", make a mistake in group, pretend you misunderstand someone in a conversation, and see what happens, Or, if it is "I must be perfect" - do a sloppy job on something.

Chances are that very few people will think you are stupid if you make a mistake, or think that there is something wrong with you if you are not perfect. And even

if they do think that, does that mean it is true? And even if it is true, does that mean you are an unacceptable person, or that you are human?

Make sure these activities involve small things without major negative consequences (losing your job, flunking a course). The point is not to teach yourself to fail, but to be more self-accepting, more comfortable when "failures" do occur.

E. *Just for Fun - Especially when you are feeling depressed*

When people are depressed, they are often so caught up in their worries and in feeling rotten that they just do not notice a lot of the things that are pleasurable. Make a point at these times to treat yourself through your senses.

Focus on colours, especially bright, warm ones, and enjoy them. Focus on textures, on softness of furs, on interesting textures of wood etc. Surround yourself with your favorite sounds - music, voices, etc. It is amazing what a lift simply focussing on pleasurable things in your world can give.

Appendix E - Cognitive Therapy Interrogation

1. What important irrational belief do I want to desensitize or reduce?
2. What are my specific unreasonable or unrealistic demands connected with this irrational belief?
3. Are these beliefs or demands true?
4. What is the evidence that they are not true?
5. What is the evidence that my main irrational belief is true?
6. What are the worst things that could *actually* happen to me (and not that I could foolishly make happen) if my irrational beliefs and unreasonable demands were not fulfilled?
7. What good things might actually happen if my irrational beliefs and unreasonable demands were not fulfilled?

Ten Important Irrational Ideas

1. It is a dire necessity for an adult to be loved or approved by almost everyone for virtually everything he does.

2. One should be thoroughly competent, adequate, and achieving in all possible respects.

3. Certain people are bad, wicked or villanious and that they should be severely blamed and punished for their sins.

4. It is terrible, horrible, and catastrophic when things are not going the way one would like them to go.

5. If something is or may be dangerous or fearsome, one should be terribly occupied with and upset by it.

6. Human unhappiness or happiness is externally caused and that people have little or no ability to control their sorrows or rid themselves of their negative feelings.

7. It is easier to avoid facing many life difficulties and self-responsibilities than to undertake more rewarding forms of self-discipline.

8. The idea that the past is all-important and that because something once strongly affected one's life, it should indefinitely do so.

9. The idea that people and things should be different from the way they are and that it is catastrophic if perfect solutions to the grim realities of life are not immediately found.

10. Maximum human happiness can be achieved by inertia and inaction or by passively and uncommittedly "enjoying oneself".

Source: A Guide to Rational Living by Albert Ellis and Robert A. Harper

MISTAKEN BELIEFS

1. Do not make mistakes.
2. Try to be good at everything or pretend that you know everything.
3. The less you disclose about yourself the better off you will be.
4. You are a victim of circumstances and your life is basically controlled by outside forces.
5. Other people are happy.

6. Do not let your anger out.

7. You should feel guilty if you do your own thing and others are upset by it.

8. Make sure that you please other people and that they like and approve of you.

9. Be right. Show others that your opinion is better than theirs.

10. You must earn happiness.

11. Play it safe. Do not take risks.

12. Try to become totally independent and self-sufficient.

13. If you avoid problems and unpleasant situations they will disappear in time.

14. Strive for perfection.

15. Your can draw general conclusions about people from individual statements and actions.

16. Some people are better than others

17. The either/or mistake.

18. Performing well is important for fulfillment.

19. You can believe most of what you hear. Your own peculiar thoughts are to be taken very seriously.

20. Therapy cannot hurt you.

SOURCE: I CAN IF I WANT TO by A. Lazarus and A. Fay

Department of Psychiatry - Day Therapy Program Edmonton General Hospital

Objective

The Day Therapy Program offered by the Edmonton General Hospital serves to facilitate earlier discharge from hospital; prevent readmissions by providing a transitional facility between in-patient care and a return to the community; and as an alternative to in-patient treatment.

A variety of groups are implemented to provide a learning experience for development of the individual's optimum level of emotional, physical and social well being. The rationale for group psychotherapy is that most behavior patterns and emotional responses have been learned and experienced in group settings, e.g., family, school and the work place. It is believed that patterns of behavior can be re-learned. Participants gain understanding of themselves and how they interact with others and have an opportunity to test out new behaviors in groups. They are assisted in effecting change through learning specific skills, e.g. communication, assertiveness and socialization.

Program Details

Participants are admitted to the Program through the hospital Admitting Department on referral from a

psychiatrist or a General Practitioner, having been assessed and accepted by the Day Therapy personnel. Each participant will have a therapist who will guide him or her in setting and achieving personal goals.

The groups are run by professionals from several disciplines, e.g. Social Services, Psychiatry, Psychology, Nursing and on an occasional basis, from others such as Dietary.a The Program is not a course and no tests or examinations are administered.

Location

The Psychiatric Day Therapy is located at the Edmonton General Hospital on the 8th Floor of the R Wing.

Time

The Program starts at 0900 hours and ends at 1530 hours Monday through Friday except on statutory holidays and is approximately 6 to 8 weeks in length.

Participation

To receive the greatest benefit from the Program, it is important to participate fully for the entire period. Absence from the Program without reasonable cause is discouraged and if this occurs for a period of 48 hours without contact, the participant may be discharged.

It is the responsibility of each participant to register his or her attendance daily, to arrange

appointments and other engagements outside of program hours and to notify the staff of absence due to illness or other unforeseen circumstances.

Source: Day Therapy Manual